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### (Debate) Medicare: Did the Devil Make Us Do It?

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## DEBATE

### MEDICARE: DID THE DEVIL MAKE US DO IT?

In this lively and creative debate, Professors David Hyman and Jill Horwitz argue about the virtues and vices of the federal Medicare program. As some predict a bleak future for the American's government's ability (or inability) to continue paying for Medicare as the population ages, this debate shows that there is genuine disagreement about the severity of the problem.

In his Opening Statement, Professor Hyman offers a satirical letter to the Devil from one of his demonic servants, describes the Medicare program through the lens of the seven deadly sins. Arguing that Medicare's faults are represented in each sin, the servant promises that Medicare is on track to "destabilize the virtue of the American republic." Hyman's fictional minion predicts that, unless the federal government enforces "fiscal discipline" on the program, the Medicare program will "implode within two generations." Hyman advocates for a market-based solution, believing that "[i]f people spending their own money don't want what the Medicare program is offering, we are by definition spending more on health care than we should, and, in doing so, we are undermining the fiscal integrity of the nation as a whole." He writes, "[o]nly the Devil could come up with something that fiendishly clever."

Professor Horwitz responds by arguing that some of Medicare's supposed vices to be not as sinful as Hyman presents them and that "there may be some virtue buried in that program design." While she agrees that the Medicare system as it exists today is flawed, she counters that Hyman's "preferred design, one more oriented to the market, would generate plenty of its own injustice." Horwitz ultimately argues for a smarter, more effective Medicare program, one that applies "the many tools that we have in our toolbox" and would involve a "more comprehensive implementation than we've had before." These changes and modifications should aim to towards "controlling spending and improving quality," but Horwitz also urges caution in making those changes, as any step will have reverberations that will be felt everywhere."

## OPENING STATEMENT

*Medicare: Did the Devil Make Us Do It?*David A. Hyman<sup>1</sup>

## INTRODUCTION

In 2004, I was invited to a conference celebrating the 40th anniversary of Medicare—the federal program that provides health insurance to approximately forty-two million (primarily elderly) Americans. At the conference, I presented an article satirizing the excesses and dysfunctions of Medicare. See David A. Hyman, *Medicare Meets Mephistopheles*, 60 WASH. & LEE L. REV. 1165 (2003). The article takes the form of a memo from a junior bureaucrat in the Department of Illness and Satanic Services (“DISS”) to the Devil, reporting on the progress of their plans to create a program (Medicare) that incorporates all seven of the deadly sins and undermines the distinctively American virtues of thrift and truth-telling.

The paper was subsequently expanded into a book, *Medicare Meets Mephistopheles* (2006). Professor Jill Horwitz wrote a lengthy review of the book, which appears in the Michigan Law Review. See Jill R. Horwitz, *The Virtues of Medicare*, 106 MICH. L. REV. 1001 (2008). The editors of PENNumbra have graciously agreed to provide a forum for author and critic to engage directly with one another.

This initial installment summarizes the central themes of the book. Professor Horwitz will then summarize her review. I will respond, and then Professor Horwitz will have the last word.

With that out of the way, on with the satire:

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<sup>1</sup> Richard & Marie Corman Professor of Law and Professor of Medicine, University of Illinois.

## MEMORANDUM

To: His Most Exalted Satanic Majesty  
7th Circle of Hell, Hell

From: Underling Demon 666  
Deputy Assistant Special Coordinator for  
Accelerating Recruitment (“DASCAR”)   
Department of Illness and Satanic Services  
 (“DISS”)

Re: Market Share Report—United States of America

Per your request, I report herein on the progress of our attempts to corrupt the American republic. Happily, our market share in the United States grows with every day that passes. Our growth has been particularly precipitous since we repackaged our product in 1965.

As you know, the recipe we have used for centuries (avarice, gluttony, envy, sloth, lust, anger, and vanity—known hereinafter collectively as the “Seven Deadly Sins”) has always worked perfectly well in most of the known world. Unfortunately, Americans proved curiously resistant to the charms of the Seven Deadly Sins. Through almost two centuries, Americans persisted in doing unto others as they would have done unto to themselves, working hard and playing by the rules, staying in school, saving for a rainy day, going to church, donating to charities, volunteering their time to worthy causes, and generally behaving like goody-two-shoes at every conceivable occasion. Although we have long had considerable success with our recruiting efforts among certain groups of Americans (i.e. members of Congress and lawyers), these groups were unable to do serious damage as long as the rest of the population behaved itself.

As such, it was a stroke of evil genius for your eminence to come up with the idea of creating a governmental program that would corrupt everything and everyone it touched. *See SATAN, DESTABILIZING THE AMERICAN REPUBLIC WITH A GOVERNMENT-MANDATED INTER-GENERATIONAL PYRAMID SCHEME* (Brimstoneware Press 1964). The program works insidiously, so that the citizenry do not perceive its consequences until it is far too late. Indeed, they vigorously defend the program against all criticisms, and, ironically enough, believe the program’s critics are allied with us!

I refer, of course, to the Medicare program, whose every feature bears the distinctive stamp of your subtle genius. This memo reviews each of the seven deadly sins and details the ways in which the Medicare program incorporates and reinforces each sin. It then outlines how the Medicare program allows us to undermine the distinctively American virtues of thrift and truth-telling. Finally, it outlines the risk of exorcism, which has the potential to undo our demonic plans.

## I. THE SEVEN DEADLY SINS OF MEDICARE

### A. *Avarice*

Avarice primarily affects the 1.3 million providers who deliver goods and services to Medicare beneficiaries. Medicare has resulted in an artesian well of money for these providers—but the whole point of avarice is that more than most is never quite enough. Providers accordingly agitate ceaselessly for increases in Medicare payments—and as a concentrated special interest, they have had considerable success in extracting ever-increasing sums from the federal fisc. Consistent with our larger goals, Medicare's compensation arrangements pay providers based on their inputs (procedures performed or time spent) and not their outputs (high quality care actually delivered), creating predictable results on the quality and cost of care actually delivered.

### B. *Gluttony*

Gluttony primarily affects Medicare beneficiaries. At the outset of the Medicare program, the costs of care (both per beneficiary and total) were relatively modest, and beneficiaries were responsible for a substantial percentage of the cost of care. The politics of Medicare created a one-way ratchet, shifting the distribution of costs toward those paying for the Medicare program (i.e. the working population) and away from Medicare beneficiaries. Because the working population is, as a group, less well off than those on Medicare, our efforts have resulted in a reverse-Robin Hood health care scheme, which robs from the (working) poor and gives to the middle and upper classes.

### C. *Envy*

Because Medicare's payment system is heavily influenced by local costs of production, and total payments are similarly affected by local treatment patterns, the cost to the Medicare program (and hence the

amount of resources spent per beneficiary) varies greatly among the several states, as well as within those states. One group of commentators has estimated that we could buy each and every Medicare beneficiary in Florida who agreed to receive their health care in Minnesota a new fully-loaded Lexus GS400 and the Medicare program would still come out ahead. See John E. Wennberg, Elliot S. Fisher, & Jonathan S. Skinner, *Geography and the Debate Over Medicare Reform*, HEALTH AFF. W96, W96-W97, Feb. 13, 2002, available at <http://content.healthaffairs.org/cgi/reprint/hlthaff.w2.96v1.pdf>.

These geographically-based disparities, and the envy they have triggered, precipitated a “formula fight” among the several states, complete with litigation and coalitions of aggrieved states and senior citizens. We are particularly lucky that the Senate Finance Committee is disproportionately composed of Senators from low-cost states, who are extremely aggrieved that the Medicare money train does not unload their “fair share” of Medicare money in their jurisdictions.

#### D. *Sloth*

Sloth primarily affects program administrators. Program administrators care a lot about cost, a bit less about access, and, at least historically, not at all about quality. This is no accident; indeed, the fundamental structure of Medicare was designed at every turn to reflect these priorities. Any provider who meets the (limited) entry requirements is entitled to participate in Medicare, and patients are free to choose any provider who will have them—meaning that program administrators have little or no ability to keep out of the program providers whose quality they are unimpressed with or to reward providers whose quality is exemplary.

#### E. *Lust*

The Medicare program induces lust for program expansion among Democrats. Although we periodically tantalize Democrats with proposals to add the “near-elderly” to Medicare, we adhere to your original plan to resist program expansion at all costs. As you correctly perceived many years ago, allowing everyone into Medicare will immediately bankrupt the program, as the cross-subsidies which sustain Medicare are only achievable if there are sufficient marks *outside* the program to pay the necessary funds *into* the program. Medicare’s beneficiaries understand this point perfectly well; the demise of President Clinton’s Health Security Act was inevitable once it became clear it would “take” from the elderly and “give” to the uninsured.

Medicare also provides Democrats with the tools to satisfy their lust for power. Of course, the lust for power is innate in all politicians and political parties. However, Democrats disproportionately emphasize Medicare in their appeals to the electorate, and have used the program as a bludgeon against their Republican adversaries at every conceivable turn, regardless of the actual magnitude of differences between the parties, the bipartisanship of the effort, and the financial straits in which the Medicare program finds itself.

*F. Anger*

Medicare triggers anger among Republicans. Democrats have successfully positioned themselves as the protectors of the Medicare program and of program beneficiaries. The Republicans cannot “outbid” the Democrats on Medicare without busting the budget, and their efforts to revise the financing of Medicare and its delivery options are routinely and effectively demagogued.

Not surprisingly, Republicans are angry about the effectiveness with which a large command and control program, that is inexorably gobbling up an ever-increasing share of federal tax revenues, has become a sacrosanct feature of American politics. The madder they get, the less credible their efforts to escape the box in which your eminence has placed them.

I also note that the debate over the 2003 Medicare prescription drug benefit caused the parties to switch sins, at least temporarily. Republicans’ lust for political power caused them to vote for a dramatic expansion of Medicare, even though doing so was flatly inconsistent with their long-standing concerns about the fiscal integrity of the program and its impact on the budget. Similarly, the design of the prescription drug benefit and their inability to claim credit for program expansion made Democrats so angry they asserted that G.O.P. stood for “Getting Old People.” See Hyman, *supra*, at 64 (quoting Ed Markey, *NewsHour with Jim Lehrer: Medicare Rx Debate* (PBS television broadcast June 27, 2003) (transcript available at [http://www.pbs.org/newshour/bb/health/jan-june03/medicare\\_06-27.html](http://www.pbs.org/newshour/bb/health/jan-june03/medicare_06-27.html))).

*G. Vanity*

Normally, policy analysts are stereotypical “goo-goos,” insisting on the dotting of every “I” and the crossing of every “T” before they will allow government money to be spent on anything. Yet, in Medicare,

the same analysts have bestowed their enthusiasm on a program that systematically and routinely pays (and frequently over-pays!) for the mistreatment of the vulnerable Americans left in its charge. Your efforts have led them to reason *sub silentio* that a program offering a rotten benefits package, mediocre quality health care, and run-away costs is better than no program at all.

## II. UNDERMINING AMERICAN VIRTUES

A program incorporating the seven deadly sins would never attain its intended objectives unless we simultaneously undermined the two American virtues that would otherwise impede our efforts: thrift and truth-telling.

### A. Thrift

As you know, Medicare's financing is structured so that current beneficiaries are paid with funds secured from current taxpayers—frequently referred to as “pay as you go.” Demographic trends and the ever-increasing cost of health care ensure that the program's economics are simply unsustainable—a fact that was clear even before the prescription drug benefit made things worse, when it was added in 2003. The extent to which Medicare, with its “promise now, pay later” approach has succeeded in undermining thrift is exemplified by the comments of the U.S. Comptroller General, who described Medicare on 60 Minutes as a “fiscal cancer.” *60 Minutes: U.S. Heading For Financial Trouble?* (CBS television broadcast July 8, 2007), *available at* <http://www.cbsnews.com/stories/2007/03/01/60minutes/main2528226.shtml>.

To summarize, we are lucky that no one has (so far) “connected the dots” of the fundamental features of Medicare:

1. Short-term viability dependent on continuous addition of new participants/funds;
2. Unsustainable long-term promises;
3. Early “investors” paid off with subsequent “investor” contributions;
4. Arguments from security/fidelity/solidarity to ensure continued participation.

Once these dots are connected, it is clear that Medicare is of a piece with one of your most successful initiatives—the pyramid



scheme—this time structured on an inter-generational basis. Pyramid schemes are invariably shut down as soon as they are discovered, on the grounds that those who were suckered at the outset have no right to share their misery with others. Pyramid scheme organizers are also treated harshly by the legal system, on the grounds that defrauding hundreds or thousands of people is much worse than defrauding a handful of people. Indeed, were anyone other than the United States government running the Medicare program, those responsible would already be serving long prison terms for fraud. However, you cleverly positioned Medicare as a sacred inter-generational trust, suggesting rhetorically that the pyramid scheme must be maintained, if not expanded, at every conceivable occasion.

Despite our repeated efforts to disguise the truth about Medicare through the endless repetition of misleading rhetoric (principally the phrase “trust fund”), many Americans are coming to realize that Medicare is, in fact, an elaborate inter-generational pyramid scheme. Indeed, no less a “New Democrat” authority than *The New Republic* has been forced to observe, “if there’s a big problem with Medicare these days, it’s the program’s lack of long-term financial viability.” See Hyman, *supra*, at 81 (quoting Jonathan Cohn, *The Single Guy*, THE NEW REPUBLIC, Nov. 22, 2002, ¶ 12). Thankfully, our framing of the Medicare program as a sacred inter-generational trust has significantly dampened the outrage that would otherwise result; the New Republic would not have been nearly as complacent had the sentence been “if there’s a big problem with Enron these days, it’s the company’s lack of long-term financial viability”—although the principal difference between the two arrangements is that Medicare’s “lack of long-term financial viability” is much worse than Enron’s.

### B. *Truth-Telling*

As you predicted, entitlement programs have provided numerous opportunities for political dissembling. The ceaseless use of misleading terminology, such as trust fund, is one aspect of the phenomenon. This terminology is used to suggest that Medicare contributions are being saved, even though the money that comes in is spent as soon as it is received, or it is loaned to the Treasury in exchange for a commitment binding on future taxpayers.

Yet, the full effects of Medicare on political truth-telling are best manifested by the whoppers politicians will tell to justify their attempts to save the program from self-destruction, or to extract political advantage from the “reform” proposals of their opponents. Both Repub-

licans and Democrats know they are unelectable if they speak candidly about the economic problems facing Medicare. The Republicans accordingly package their reform proposals as attempts to “modernize” the Medicare benefit package, and offer beneficiaries more options. The Democrats focus their efforts on price caps and prayer. Neither approach is likely to lead to the minimum expected of a private insurance plan or investment—actuarially and economically sustainable promises to purchasers/investors.

### III. THREATS TO THE DEMONIC PLOT

Our strategy has been so successful that there is only a limited prospect of exorcism. The most concrete threats are proposals to fully means test Medicare or convert it into a defined contribution plan. Other risks include the outright repeal of Medicare Part D and Medicare’s increasing enthusiasm for leveraging its purchasing power to enhance quality and lower cost. Any of these reforms will fragment the coalition of support that currently sustains the inter-generational pyramid scheme we have created and nurtured.

### IV. SUMMARY

All of the building blocks are in place for our plans to destabilize the virtue of the American republic. The Medicare budget is heading for a brick wall at an accelerating rate. Every attempt to impose fiscal discipline triggers squeals of outrage from affected providers, beneficiary groups, and true believers in the inter-generational pyramid scheme you have created.

Our best calculation is that the Medicare program will completely implode within two generations—and efforts to “reform” Medicare will extend the process only slightly, while simultaneously breeding dissension and class warfare—precisely the objectives outlined in your original memo.

Have a hellish day.

### CONCLUSION

Of course, Medicare is not a demonic plot, and it is libelous to suggest so (or would be, if one could libel a government program). However, satire provides a tool with which to explore some of Medicare’s problems in a less confrontational way than might otherwise be the case. At least that’s my story, and I’m sticking to it.

Despite the claims of its defenders, Medicare is not a sacred bond between the generations. It is just another government program—and a pretty mediocre one at that.

The first rule of holes is simple: when you find yourself in one, stop digging. *Medicare Meets Mephistopheles* is a satirical attempt to provoke Medicare's defenders and the American public to acknowledge that we are in a hole and that we should stop digging.

## REBUTTAL

*Medicare and the Cardinal Virtues*Jill R. Horwitz<sup>†</sup>

As Professor Hyman mentioned in his Opening Statement, our first PENnumbra exchange summarizes much longer works—Professor Hyman’s recent book and my review in the Michigan Law Review. See Jill R. Horwitz, *The Virtues of Medicare*, 106 MICH. L. REV. 1001 (2008). For those with the fortitude to engage the details—and one of my main points in this Rebuttal is that in toting up the vices and virtues of Medicare, the details matter—I urge readers to consult the longer works.

Despite rumors to the contrary, Professor Hyman does not work in the Devil’s employ. He really wants to make the health care system better and, in doing so, to make us all healthier and happier; he thinks the best way to do it is to eliminate the Devil’s handiwork—big government. I confess that the idea of relying on the market to provide health care has theoretical appeal. We mainly rely on the market to provide goods that are just as, if not more, important than health care. We may regulate the provision of food and housing quite extensively, but we manage to get them to millions of people through pretty well-functioning markets and without anything like all the kerfuffle about health care. Newspapers and scholarly journals are not filled with endless streams of articles bemoaning the growth of spending on either. So why not just get rid of all this unnecessary bureaucracy?

It turns out that conducting an exorcism isn’t so easy. If you are looking for evidence of a demonic presence here on Earth you need to look in a place far less obvious than a government program; you need to look deeper, into the very nature of health care. Who else but the Devil would create illness so rampant, medical treatment so complex, knowledge so limited, and the need for such fast decision-making? This is why health care markets are filled with failure, and the government, mostly, isn’t to blame.

That is not to say that Professor Hyman’s assessment of Medicare—that it spends too much, for the wrong reasons, on second-rate stuff, and from the pockets of the poor—entirely misses its mark.

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<sup>†</sup> Assistant Professor of Law, University of Michigan Law School, and Faculty Research Fellow, National Bureau of Economic Research.

Medicare is enormous, and it's growing fast. (Though whether its growth is unsustainable is an open question.) We ought to do a better job at considering its distributional consequences. A closer look at Professor Hyman's complaints reveals that maybe Medicare isn't as sinful as he suggests. In fact, there may be some virtue buried in that program design.

## I. MEDICARE'S VICES ACCORDING TO HYMAN

### A. *Avarice*

Medicare is vast. It covers approximately forty-four million people and spends over \$370 billion dollars every year. (And, by the way, Medicaid spends almost just as much.) Pretty soon even these dollars might come to look like pocket change. Some analysts predict that by 2050, Medicare spending alone will increase to 9.2% of GDP from 2.6% in 2005, both because of growth in the cost of medicine and the graying of America. See David M. Cutler, *The Potential for Cost Savings in Medicare's Future*, HEALTH AFF. W5-R77, W5-R78, Sept. 26, 2005, available at <http://content.healthaffairs.org/cgi/reprint/hlthaff.w5.r77v1>. It's even worse than that. If you are looking for a culprit for *total* spending, you can blame Medicare for inducing more *private* spending on health care as well as public spending. See Amy Finkelstein, *The Aggregate Effects of Health Insurance: Evidence from the Introduction of Medicare* 15 (Nat'l Bureau of Econ. Research, Working Paper No. 11619, 2005).

Evidence of spending, however, isn't evidence of avarice. Most health care providers aren't stealing money. They are being paid for providing medical care. Why should we care how much money we spend on health care anyway? Per capita health spending varies considerably (more than 100 to 1) across nations. See William D. Savedoff, *What Should a Country Spend On Health Care?*, 26 HEALTH AFF. 962, 962 (2007). Ironically, spending on medical care is lower in countries with public systems than with private systems. See David M. Cutler, *Health Care and the Public Sector*, in HANDBOOK OF PUBLIC ECONOMICS 2143, 2168 (Alan J. Auerbach & Martin Feldstein eds. 2002). People have to spend their money on something. The percentage of GDP spent on health care can be understood as a matter of national choice, not whether the country can afford the bill. Many people argue that the U.S. has made the right choice in spending on health care because it has meant that we are living longer and healthier lives. See Michael E. Chernew et al., *Increased Spending on Health Care: How*

*Much Can the United States Afford?*, 22 HEALTH AFF. 15 (2003). Some have even argued that over time we ought to be spending even *more* than we are today. See Robert E. Hall & Charles I. Jones, *The Value of Life and the Rise in Health Spending*, 122 Q.J. ECON. 39, 40 (2007). So spending *per se* isn't a problem. It is a problem, however, if it means that we have to give up too many other goods that matter for our quality of life. If more spending on health care means less education for children then that's a problem. But if it means a little less violent entertainment, that might be evidence not of a sin, but of a virtue—prudence.

A harder question than whether we are spending too much on health care is whether we are spending efficiently. Inefficiency explains some, although not all, of why U.S. health spending is higher than health spending elsewhere. This doesn't necessarily mean that we should spend less even though it does mean that we should spend smarter. This is because variations in spending patterns are so complex—additional spending in some regions is worth it and in others is not—you don't improve the efficiency of Medicare spending by simply refusing to buy the next dollar of health care.

### B. Gluttony

“Underling Demon 666” is perhaps proudest of Medicare's ability to tempt people into spending more of their money—and even more delicious, other people's money—on health care than they would absent insurance. Medicare's supposed Gluttony refers to two distinct problems that are critical to disentangle: (1) moral hazard and (2) inequitable distribution.

Moral hazard is an inevitable cost of insurance. It occurs when an individual is less careful than usual or consumes more than she otherwise would because she doesn't have to pay all the costs of an accident or her consumption. Although people may not be less careful with their bodies just because they have insurance, they do go to the doctor more. Professor Hyman thinks that Medicare has turned its patients into diners who take an extra trip to the all-you-can-eat buffet. They are plenty full and wouldn't order another course if they had to pay for it, but, because they don't, they pile the food on their plates.

No doubt some people buy an extra course of care that they don't need just because Medicare picks up the tab. Yet the analogy is stretched. People generally become patients because they are sick, not because they are insured. Medicine isn't like food; it doesn't usually taste good. And unlike estimating the cost of an additional serv-

ing of dessert, measuring moral hazard in the health care context is notoriously hard. Doing it the usual way—looking at what people would consume absent insurance and deciding the rest is moral hazard—isn't accurate. People mostly consume more medical care when they are insured because they can't afford it otherwise. They may very well value it at much more than its cost. So, yes, health insurance induces many patients to get the surgery, but this is often the virtue of insurance, not its vice.

### *C. Gluttony II*

One of Professor Hyman's biggest concerns is that Medicare is a reverse-Robin Hood scheme. Because of its reliance on payroll taxes, it takes from the young and the working poor and gives to the retired wealthy. Here the Devil is in the details. Let's consider a few different questions about the way Medicare redistributes.

(1) Does Medicare transfer money from workers who are young to retirees who are old? Yes, it's supposed to. Elderly retirees need health insurance more than younger workers because, on average, they get sick more. Besides, young people turn into old people; they'll not only have their turn to be beneficiaries—they'll be quite happy to find that they are consuming something much better: tomorrow's medicine.

Professor Hyman worries that the young won't ever get their turn because Medicare is a pyramid scheme that is going to come crashing down. This is debatable. Whether transfers will grow depends on how medicine changes and how much it will cost. For example, we don't know whether genomic developments will make medicine more or less expensive and efficient. Further, demographics are not destiny. Whether Medicare, like other large social insurance programs, is sustainable depends on economic growth. Historically, each successive generation is more productive than the last. Even so, forecasting fifty years and more into the future is a perilous business. Neither pessimism nor optimism is justified.

Regardless, restructuring Medicare to avoid these explicit intergenerational transfers will not necessarily help. Absent Medicare, elderly people would find some way to get care and cost-shifting would abound, whether they would go onto Medicaid, to emergency rooms, or to their children for financial help. Younger people, particularly taxpayers, will pay one way or another.

(2) Does Medicare transfer monetary value from the poor to the rich? It depends on how you count. The rich live longer so they are both more likely to 1) live long enough to get Medicare and 2) enjoy its benefits for more years. But they also pay more taxes than the poor. So the evidence on monetary transfers is mixed. *See, e.g., Jay Bhattacharya & Darius Lakdawalla, Does Medicare Benefit the Poor?*, 90 J. PUB. ECON. 277, 278 (2006) (finding evidence of transfers from the rich to the poor).

(3) Is Medicare inequitable *among* the old? That is, do the rich beneficiaries get more out of the program than do the poor beneficiaries? Probably—but the poor show net gains too, and the gap is shrinking. *See* Mark McClellan & Jonathan Skinner, *The Incidence of Medicare*, 90 J. PUB. ECON. 257, 258 (2006); Jonathan Skinner & Weiping Zhou, *The Measurement and Evolution of Health Inequality: Evidence from the U.S. Medicare Population 2* (Nat'l Bureau of Econ. Research, Working Paper No. 10842, 2004).

(4) How do rich compare to poor beneficiaries in terms of health outcomes? Again, everyone benefits, but the poor probably do better. *See* Skinner & Zhou, *supra*, at 2.

So, yes, there is evidence of inequitable redistribution. But what should we do with this fact? I think that we should strive for temperance. Why? Because I doubt those poor patients want to give up those life years they gained from the program just because someone else got a better deal.

#### D. Envy

Unfortunately, it's still too early in the analysis to start dancing on the Devil's grave. Professor Hyman is right to bemoan what can only be described as shocking geographic variation in patterns of hospital use, surgery, and medical spending. One look at a map of medical treatment patterns is enough to make patients very queasy.

Medicare's design, however, is only one of plenty of explanations for this variation, many of which have to do with the nature of health care and the scale of social insurance programs. Incentive systems can't be perfect. Information is hard to disseminate. Monitoring is costly. Medical science is an uncertain business.

Further, we don't know whether private alternatives would do any better than Medicare at solving these problems. There are no neat case control studies with relevant control groups because almost all the elderly are covered by Medicare. There are plenty of studies comparing various experiments within Medicare, but none that would



allow anyone to conclude that elderly patients would spend less or get higher quality care without it. Perhaps Americans are practicing temperance by not embracing the free market.

## II. MEDICARE'S VIRTUES

### A. *Wisdom*

Rather than continuing to address each vice and urge readers to look a little deeper before despairing about Medicare, I'd like to shift the focus of the discussion to how we *should* measure whether Medicare has been a success or a failure. Health and monetary benefits are important, but they aren't the only things that matter. What about Medicare's value as an *insurance program*, one meant to reduce the risk of high out-of-pocket spending on health care when it is needed? What are the net insurance benefits for the elderly? For the poor? For the rich? In other words, how valuable is Medicare insurance in terms of risk protection to the elderly, many of whom were uninsured before the program was started?

Before Medicare was enacted, many poor people were uninsured or underinsured. Medicare provided risk protection to people who were previously unable to get it. So it's important to identify what Medicare provided in terms of *insurance* value to its beneficiaries and to identify "the *differential* insurance value between high and low income households . . ." McClellan & Skinner, *supra*, at 258. From this perspective, the results look pretty good. Beneficiaries at every level of income show net gains from having access to the insurance provided by Medicare and the poor show bigger gains than the rich. *Id.* at 270.

### B. *Fortitude and Justice*

Even if Hyman is right about all this, we are left with the question of what to do? Should we let the entirety of Medicare burn in Hell? Since massive social programs are inevitably flawed, how should we balance the various injustices? Hyman focuses on Medicare's financing, oversight, and political problems. Yet his preferred design, one more oriented to the market, would generate plenty of its own injustice. Why is that better?

It is too much to ask of anyone, even the Devil, to provide the diagnosis and the treatment for Medicare in a single rebuttal. So I hope we'll get there in the next round.

## CLOSING STATEMENT

*Cooling Out the Marks, Medicare Style: Balancing  
Demonic Vices and Cardinal Virtues*

David A. Hyman

I appreciate Professor Horwitz's willingness to review my satiric book on Medicare, as well as the care and good humor with which she undertook the task. That she was willing to do so when she was pre-tenure and had countless better things to do leaves me doubly in her debt. Finally, she has added to my debt by her willingness to participate in this online exchange.

I particularly appreciate Professor Horwitz's opening stipulation that "[d]espite rumors to the contrary, Professor Hyman does not work in the Devil's employ." Although I winced a bit at "rumors to the contrary," this is still considerable progress from a conference early in my career, when a senior colleague in health law asserted that "mine [were] the sort of views that caused the Irish potato famine." David A. Hyman, *Medicine in the New Millennium: A Self-Help Guide for The Perplexed*, 26 AM. J.L. & MED. 143, 152 & n.43 (2000). In all fairness, Professor Horwitz's formulation does not exclude the possibility that I am an independent contractor working for the Devil—but that is the sort of smart-mouthed observation that only a wiseacre former tax lawyer (i.e. me) would make.

Let me begin with a half-dozen of the numerous areas of agreement between author and critic:

1. We agree that details matter, and readers should consult the longer works to get the full flavor of both the book and the review.
2. We agree that Medicare is enormous, growing fast, and its distributional and economic consequences should be more closely considered than has previously been the case.
3. We agree that health care markets are complex and that government is not to blame for all the deficiencies in their performance.
4. We agree that Medicare is buying lots of care whose quality leaves much to be desired—in part because of perverse incentives, such as paying the same amount (if not more) for low quality care than for high quality care.

5. We agree that there are “virtues buried in the Medicare program” and that I slight them. (To be sure, to complain that a satirical polemic is not “fair and balanced” is to miss the point of the genre. More broadly, despite Professor Horwitz’s title, the virtues she identifies are neither the “cardinal virtues” of prudence, temperance, fortitude and justice, nor the theological virtues of faith, hope, and charity—although Medicare does considerably better when judged by the latter (hope) than the former (prudence). (It is unclear why two Jews have any business debating Catholic doctrine. Blame Professor Horwitz. She started it.))
6. We agree that Medicare succeeded in providing universal coverage to a population that the private market was not covering. Doing so required hundreds of billions of dollars per year—which we agree that Medicare is spending inefficiently, while not doing much to purchase population health.

Lest the reader think that there is universal agreement, where do author and critic disagree?

First, we disagree on whether Medicare is sustainable in anything like its current form. Professor Horwitz says that this is an “open question” that is “debatable.” She doesn’t have much company in that position. Every year, Medicare’s public trustees issue a report politely noting that the current trends are unsustainable and reporting the number of years until the Part A “trust fund” is exhausted. The latest report, issued last month, includes the second consecutive “Medicare funding warning” and calls for “timely and effective action to address Medicare’s financial challenges . . . [including] the exhaustion of the HI trust fund and the anticipated rapid growth in HI, SMI Part B, and SMI Part D expenditures.” 2008 Annual Report of the Board of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds 4, <http://www.cms.hhs.gov/ReportsTrustFunds/downloads/tr2008.pdf>. As I noted in my original submission, the U.S. Comptroller General was less polite, referring to Medicare as a “fiscal cancer.” He also described the recently enacted prescription drug benefit as “probably the most fiscally irresponsible piece of legislation since the 1960s”—i.e. since the date when Medicare was created. *60 Minutes: U.S. Heading For Financial Trouble?* (CBS television broadcast July 8, 2007), available at <http://www.cbsnews.com/stories/2007/03/01/60minutes/main2528226>.

shtml. He has since quit his job as Comptroller General, and is working full-time on a “fiscal wake-up tour” that focuses on the federal budgetary implications of entitlement programs like Medicare. Reasonable people can disagree on whether the program’s unfunded liabilities are exactly \$36 trillion, as estimated by Medicare’s trustees to cover the next seventy-five years (or \$85 trillion for an indefinite time horizon), but one needs a stronger argument than that it is “an open question” to dispute the bipartisan agreement on the fiscal and budgetary fix we find ourselves in. See Joseph Antos, *Medicare’s Bad News: Is Anyone Listening?*, AEI HEALTH POLICY OUTLOOK (Am. Enter. Inst. for Pub. Pol’y, Washington, D.C.), Apr. 2008, at 3, *available at* [http://www.aei.org/publications/filter.,pubID.27825/pub\\_detail.asp](http://www.aei.org/publications/filter.,pubID.27825/pub_detail.asp).

We also disagree on the extent to which health care spending and moral hazard are serious problems. Professor Horwitz states that overall spending can’t be a problem unless it keeps us from buying things we really need, and moral hazard can’t be that big a problem, because no one voluntarily chooses to consume health care. Space precludes a full response, but a simple thought experiment makes the point. If we offered program beneficiaries the cash value of the risk-adjusted premium necessary for them to purchase coverage comparable to Medicare, how many would buy back into the program? I bet relatively few would opt for the open-ended, no-expense spared, “machine that goes ping” (referring to the classic Monty Python sketch) coverage that Medicare provides. See *THE MEANING OF LIFE* (Universal Pictures, 1983). Most would use the savings (if not the entire amount) for non-medical purposes.

What about those currently paying into the system—would they continue to participate if they could opt out? Professor Horwitz must believe that they will, since her sunny prediction is that “they’ll not only have their turn to be beneficiaries, they’ll be quite happy to find that they are consuming something much better: tomorrow’s medicine.” This position is implausible on its face. Medicare is a mandatory government program precisely because it is a negative-sum game for everyone other than those who get in early and those who provide services to program beneficiaries. More bluntly, Medicare only “works” because of forced contributions from “marks” outside the system.

If people spending their own money don’t want what the Medicare program is offering, we are by definition spending more on health care than we should, and, in doing so, we are undermining the fiscal integrity of the nation as a whole. The satiric thesis of my book

is that only the Devil could come up with something that fiendishly clever.

We also disagree on the extent to which we should be concerned about Medicare's distributional implications. Professor Horwitz argues that Medicare beneficiaries are all better off as a result of the program. However, this argument misses the point—one does not judge the merits of a pyramid scheme by looking at the amounts received by those lucky enough to cash out early. As I said previously, the essence of Medicare is that it robs from the (working) poor and lower middle class (who are disproportionately uninsured) in order to pay for insurance for the middle and upper classes. One might defend this arrangement (with some degree of embarrassment) on the grounds that everyone will get their fair share eventually, but if the projections about Medicare are even remotely close to right, that just isn't going to happen. It is for this reason that virtually all employers (including the state of Michigan, where Professor Horwitz works) have abandoned defined benefit retirement plans (which Medicare is modeled on) and adopted defined contribution plans.

Although Professor Horwitz agrees with me that there are numerous deficiencies with the Medicare program, she argues that comprehensive market-oriented reform is inappropriate since a market-based system will "generate plenty of its own injustice." No system is perfect, but the strategies outlined in my book (including means testing, paying beneficiaries a risk-adjusted defined contribution, repeal of Medicare Part D, greater competition, and prudent purchasing) are more likely to focus our resources on those who need it the most, and do so in a more affordable and sustainable fashion than the status quo. What's so demonic about that?

To highlight the challenges created by Medicare, and give Professor Horwitz a broader target at which to shoot, let me offer a satirical job posting for the next program administrator:

*Wanted: Medicare Administrator*

*Salary:* Not nearly enough, given what you have to put up with.

*Top Ten Tasks:*

1. Spend less on health care (to keep Congress and the Administration from calling for your head);
2. Spend more on health care to avert the 7% cut in physician payments scheduled to take effect next year (to keep

providers from calling for your head, and patients from doing so once they can't find a doctor to treat them);

3. Improve the quality of care that is delivered by using appropriate carrots and sticks—but don't interfere with the way in which providers deliver health care, particularly if the provider delivering low quality care has the ear of a Congressman or employs lots of people in a swing district;
4. Buy lots of pharmaceuticals for seniors, but don't pay too much (or Congress and the Administration will have your head) or too little (or the pharmaceutical companies will stop developing innovative products);
5. Using inadequate and dated information, set the price that will be paid by Medicare for every single good and service beneficiaries need in every county in the United States;
6. Prepare the program for the impending tidal wave of baby boomers, who will stop paying into the system and start expecting benefits in 2011;
7. Keep a straight face while you explain that the Medicare program will be there for future generations, even though your trustees have determined that putting one part of the program in actuarial balance for the next seventy-five years will require an "immediate 122-percent increase in the tax rate or an immediate 51-percent reduction in expenditures." 2008 Annual Report of the Board of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds 19, <http://www.cms.hhs.gov/ReportsTrustFunds/downloads/tr2008.pdf>;
8. Keep your temper when called before Congress to explain why the Medicare program keeps gobbling up the federal budget, when it was Congress that set the program on auto-pilot to do exactly that;
9. Save up money to live abroad once you retire, because your life won't be worth a plugged nickel once those who have paid into Medicare for their entire lives realize it won't be there for them—and also realize that those administering the program knew that all along;
10. Walk on water in your (non-existent) free time.

Finally, my reply is titled “cooling out the marks, Medicare style.” This is a reference to a well-known article by a famous sociologist, on con games and the social process of adaptation to failure:

Sometimes, however, a mark is not quite prepared to accept his loss as a gain in experience and to say and do nothing about his venture. He may feel moved to complain to the police or to chase after the operators. In the terminology of the trade, the mark may squawk, beef, or come through. From the operators' point of view, this kind of behavior is bad for business. It gives the members of the mob a bad reputation with such police as have not yet been fixed and with marks who have not yet been taken. In order to avoid this adverse publicity, an additional phase is sometimes added at the end of the play. It is called cooling the mark out. After the blowoff has occurred, one of the operators stays with the mark and makes an effort to keep the anger of the mark within manageable and sensible proportions. The operator stays behind his team-mates in the capacity of what might be called a cooler and exercises upon the mark the art of consolation. An attempt is made to define the situation for the mark in a way that makes it easy for him to accept the inevitable and quietly go home. The mark is given instruction in the philosophy of taking a loss.

Erving Goffman, *On Cooling the Mark Out: Some Aspects of Adaptation to Failure*, 15 PSYCHIATRY 451, 451-52 (1952).

The occupational hazard for Medicare's defenders is the tendency to become coolers on the program's behalf. Professor Horwitz largely avoids this temptation, although she is not (yet) willing to concede how hot things actually are in the place in which we find ourselves. The same cannot be said for Medicare's more ardent defenders, who routinely justify and excuse Medicare's pathologies on the grounds that it is a “sacred inter-generational trust,” and not just another mediocre government program. Yet, even these ardent defenders may eventually find themselves wondering, in the dark of night, how it came to pass that they became coolers, giving instruction to the poor and working classes on the philosophy of taking a loss at the hands of a program that was supposed to help them, but ended up treating them as marks. With friends like that, who needs enemies?

## CLOSING STATEMENT

*Medicare for Mortals*

Jill Horwitz

Last month Medicare's Board of Trustees released their 2008 Annual Report in which they predicted Medicare spending over the next seventy-five years. As Professor Hyman points out, that the report includes yet another Medicare funding warning is cause for concern. The CBO estimates of the long-term outlook are even worse.

But let's think for a moment about what health care looked like seventy-five years ago. In 1933, scientists were experimenting with penicillin but it wasn't mass produced until 1944. The Nobel Prize in Medicine was given to Dr. Thomas Hunt Morgan for discovering the role that the chromosome played in heredity. Congress weighed in on whether to require that vitamins be put into lipstick. People were just beginning to buy health insurance. Participants at the 1933 AMA convention were urged to embrace eugenics as the hope for the country.

What were they predicting about the future of medicine seventy-five years ago? Eminent surgeons from around the world were told that

[t]he medical man of the future . . . would "tune in" on the living body as one does now on the ordinary radio. . . . Long before there was any outward evidence of disease, the physician-radio-engineer of the future would thus be enabled to tell by the "reception" of the "life-waves" whether they were playing a melody of health or whether they were signaling an SOS.

William L. Laurence, *Crile Advances Life Ray Theory as Medical Basis*, N.Y. TIMES, Oct. 9, 1933, at 1. In 1933, the editor of the Journal of the American Medical Association decried both the introduction of group medical practices and the growth of the hospital because "from 85 to 90 percent of [inpatient] cases could be treated by a general practitioner with equipment that 'can be carried in a handbag.'" *Assails Report on Medical Costs*, N.Y. TIMES, Jan. 8, 1933, at 31. That same year, attendees at a Harvard Medical School lecture were told that medicine had inappropriately disregarded the health of the elderly. *Urges United Drive to Extend Longevity*, N.Y. TIMES, Mar. 18, 1933, at 14. Who counted as the elderly? People over 50.



We shouldn't mock these people for their erroneous predictions. These prognosticators were well-educated, informed, and at the top of their professions. But they were enough degrees off that we find their guesses amusing in hindsight. Why do we think we can do any better at making predictions about what will happen in 2083? We don't know how shifts in research from anatomy to biochemistry will change medicine, never mind how much they will cost. They may save us money; they may not. Given all this uncertainty, it is not surprising that historical projections of the Hospital Insurance Trust Fund's insolvency date have varied so much.

Now pile political uncertainty onto technological and financial uncertainty. Despite years of predictions of Medicare's imminent demise, it's never happened. Why? Congress has never let it happen. Congress can, and does, change the program. It isn't bound to current federal policy, and it isn't going to let federal health care spending consume more than one-hundred percent of GDP, a prediction of some current models. Congress can limit benefits, restructure the program, or raise taxes. And perhaps raising taxes to cover some high level of care is the right answer. As I've noted in our previous exchanges, some economists have convincingly argued that previous spending hasn't been profligate but, rather, shows good investment sense—we have gotten more than our money's worth from health care spending. If this is right, we shouldn't be blinded by our worries about costs—we should be thinking, at least as much, about spending more efficiently.

Regardless, whether Medicare is sustainable over the long term is not likely a question that we can answer with much precision. It's also why Professor Hyman's Doomsday prediction that there will be no gruel left for us after today's elderly are done gorging themselves on high-tech medicine is nothing but speculation—and less supported speculation than what he calls my "sunny prediction" that tomorrow's medicine is going to be better than today's. Would you prefer blood-letting or a Tylenol for your headache?

Fortunately the question about whether the current edifice of Medicare can stand over the long term is not the most important. We should instead focus on a series of interconnected questions that we might be able to answer. How much health care do we want? What are we willing to spend on it and, therefore, what are we willing to give up in terms of consumption of other goods? How can we make sure we are buying the good stuff and not the bad stuff? How can we fairly,

responsibly, and accurately quantify the answers? How do we implement reforms while avoiding perverse incentives?

First—and here is something that Professor Hyman and I agree on—we should strive to provide care that people want and not provide care that they don't. What's the best way to determine what people want? Professor Hyman wants to offer future beneficiaries the (risk-adjusted) cash value of the coverage a beneficiary receives and ask whether they want to use it to buy Medicare coverage. He claims that they wouldn't and then concludes that this is evidence that people think Medicare is a sham—an albatross people would chuck if given a chance.

But this thought experiment misses the point of insurance. Insurance isn't meant to buy a predictable package of predetermined goods—it is supposed to protect people from the big, unpredictable hits. Ask people whether they would spend the cost of their premium to get the benefit of insurance if they end up with a catastrophic illness, even if their probability of getting some awful disease is low. Ask them if they'd like to face the choice of paying grandpa's hospital bills for some life-saving treatment or junior's college tuition. I bet that question would generate a different answer about the value of Medicare insurance than the one Professor Hyman would ask.

This brings us to a second, deeper point of disagreement: the role of moral hazard in health care consumption. Moral hazard is the ugly cousin of insurance. People will consume more when others are paying, and insurance is a way of making other people pay. Professor Hyman says that I think moral hazard can't be a big problem in health care consumption because it isn't pleasant to take medicine. My point wasn't that there is no moral hazard in health care. There almost certainly is. My response was meant to emphasize that it is very hard to tell how much moral hazard there is, where it is, and what to do about it. The risks of intervening and getting it wrong are high.

Imagine the following two insurance plans that cover eyeglass purchases. Plan 1 allows you one new pair per year and Plan 2 allows you two new pairs per year. I bet that more people under Plan 2 will get two pairs per year than those under Plan 1. Maybe a few of those people under Plan 2 buy two pairs because their prescription changed and they would have bought the two pairs even if they were insured under Plan 1. The rest are getting the second pair because someone else is paying, not because the insurance allows them to access important care that improves their health or because getting the second pair helps the rest of us (like a vaccine). The structure of Plan 2 looks wasteful, and comparing the dollar value of eyeglass purchases under

each plan is a pretty good way to quantify the waste. This, however, is a trivially easy case. Imagine the scenario of covering open heart surgery (which, by the way, attracts few casual participants).

The difficulty in examining the extent of moral hazard in the health insurance context is that having health insurance lets people get more care than they otherwise would and that additional care may be 1) wasteful, *or* 2) protective of the rest of us, *or* 3) good for the patient and worth the cost, *or* 4) some combination of these. Simply observing that people get more care when they are insured than when they aren't insured doesn't get you very far in figuring out how much moral hazard exists in health insurance or what to do about it.

Professor Hyman understands all this and thinks the free market can save us. This view of the private sector is puzzling. We have a private sector and, on average, it isn't doing any better in containing costs or cost growth than the public sector. Why? In large part because medical technology is growing, and lots of what that technology does, although not all, is to help us live longer and healthier lives.

As Professor Hyman notes, we agree that one way to get at the problem of high costs might be to do a better job on providing higher quality care. (I say "might" because providing higher quality care is not always cost-saving.) We need to figure out how to promote and pay for the good stuff and avoid the bad stuff. Fortunately, there is a lot that we can do that we aren't doing as suggested by the extreme geographic variation in medical spending, variation that implies widespread inefficiency. We are currently buying medicine that doesn't help and may even hurt people. Good estimates suggest that such spending accounts for around one-third of total health care spending. We need to figure out what we're doing wrong, and stop: not only to save enormous amounts of money, but also to save lives.

But, again, I suggest that Professor Hyman overlooks the complexity of the problem and, therefore, the difficulty of finding the right solution. Patients aren't great consumers. They have a hard time telling whether the medicine they received helped, hurt, or did nothing. Even researchers can't yet identify good, neutral, or bad spending. We can't rely only on health policy researchers pursuing their own interests to give us the answers. At a minimum, we need the kind of systematic, coordinated analysis that is best produced through targeted, government funding. See John E. Wennberg et al., *Extending the P4P Agenda, Part 2: How Medicare Can Reduce Waste and Improve the Care of the Chronically Ill*, 26 HEALTH AFF. 1575 (2007).

Understanding these complexities sheds some light on why embracing the market in the extreme through individual health savings accounts—one of the reforms that Professor Hyman hints at endorsing—would likely be harmful. Most people just want to get help from the medical system when they need it, and they don't want to have to understand all kinds of things about risk and probability to get their entry ticket. They don't know how much a plan should cost, which plan to pick, or what their expected probability of illness will be over the years. Think about how difficult it is to pick a plan for those of us who are lucky enough to have a few insurance choices. Just this year I gave a talk to my faculty on health insurance and used the University of Michigan benefits plan as an illustration. In preparation I read the charts that summarize the plan options, but found the terms hard to compare. So I did a lot of digging and read a few eighty-page contract "summaries." I couldn't ever figure out how to get the (no doubt) thousands of pages of underlying contracts that the university had negotiated on my behalf. Let's just say the search and decision costs are high.

Recent advances in economics have taught us that having more choices is not necessarily good. In the health insurance context, more choice has often meant more adverse selection, a problem that is at least as big for health insurance markets as is moral hazard. In addition, when people face complicated information and difficult choices, they often make bad choices. They tend to be too sensitive to upfront costs relative to long term gains (subprime mortgages, anyone?). Patients tend to stop taking drugs when the price goes up a little even when the long term value of the drug is enormous. Looking at another experiment in individual purchasing gives some guidance. With the growth of individual retirement accounts, average savings has gone up but so has variance. If you care at all about equality, this is a big deal.

So far in this debate I have mainly focused on the ways in which Professor Hyman's reasoning has been over-simplified and his proposals likely to lead to negative unintended consequences. But, of course, even if we knew how much moral hazard there is, which spending is wasteful, and who is gaming the system, that still wouldn't suffice.

We need to both deal with costs and cost growth. And we need to deal with the distinct issue of dangerous and inefficient spending. We should, however, do so carefully, using the right kind of incentives. So at the time we continue to investigate, we should apply the many tools that we have in our toolbox, market based and otherwise. These in-

clude information technology (for example, computerized physician order entry), pay for performance, disease management, medical protocols, preventive care, chronic care management, care coordination, and more. We've tried some of these approaches here and there, in certain regions, in pilot programs, and in small trials. That's not enough. We need more comprehensive implementation than we've had before, because piecemeal action won't cut it. If you squeeze the balloon in one place, it will bulge in another. This is one of many reasons why major reforms to huge payer programs like Medicare and Medicaid offer a unique opportunity for safety and for cost control. Helping Medicare take a step in the right direction towards controlling spending and improving quality will have reverberations that will be felt everywhere. Let's tread carefully.

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